



# Job Loss Analysis

ID No: 2000247

Status:

Original Date: 20/May/2011  
Last Review Date:

Organization:

SBU: GLOBAL MANUFACTURING  
BU: ALL  
Work Type: Technical (Process Engineering)  
Title (Work Activity): Troubleshooting a Process Problem  
Site/Region:

Personal Protective Equipment (PPE)	Selected	Comments
Proper PPE per your Refinery Guidelines		
Personal Gas Monitor		
Additional Task Specific PPE		
Other		

Reviewers

Reviewers Name	Position	Date Approved
Michelle Johansen	Process Engineerign Manager/Global JLA team leader	11/30/11
Allan Zieber	Salt Lake Process Leader	
Jim Zarbis	Sr Process Eng	
Ken Wohlgeschaffen	Sr Process Eng	
Mark Zaal	Sr Process Eng	
Patricia Roberts	Sr Process Eng	
Bart Welch	BIN Leader	
Kevin Preus	Lead Process Engineer	
Jon Peters	Lead Process Engineer	

Development Team

Development Team Member Name	Primary Contact	Position
Lee, John W (JLGZ)	Y	Process Engineer
Atwell, Audrey (ROAU)		Lead Process Engineer

Job Steps

No	Job Steps	Potential Hazard	Critical Actions
1.	Review customer requirements	<ol style="list-style-type: none"> <li>1. Failure to follow through on action items, not notifying the right people</li> <li>2. Off spec. product, damage or upsets in downstream units, downgrade of HVP, product giveaway, and curtailment of unit rates</li> </ol>	<ol style="list-style-type: none"> <li>1. Verify and confirm when the customer needs the information</li> <li>2a. Validate requirements vs. current plan (7-day or 21-day plan, etc)</li> <li>2b. Communicate w/customer if discrepancy exists</li> </ol>
2.	Review process problem with operators	<ol style="list-style-type: none"> <li>1. Not involving the right people</li> <li>2. Loss of time because not all the information about the situation collected</li> <li>3. Gaps in procedures, training, or written communication could be missed</li> </ol>	<ol style="list-style-type: none"> <li>1a. Ask operators if issue has happened before; what was done before;</li> <li>1b. Ask operators if there were any changes noticed that would cause or be related to the issue</li> <li>1c. Ask operators if there were any changes in process set points, equipment or routings</li> <li>1d. Ask operators why (if any) changes were made</li> <li>2a. Check turnovers to discover what other crews may have said</li> <li>2b. Review CPV's and current sample results</li> <li>3. Review COD (Consequence of Deviation) table and confirm any corrective actions taken</li> </ol>
3.	Review Electronic Operating Manual, PMO, PFDs and P&IDs for the system	<ol style="list-style-type: none"> <li>1. Loss of time because not all the information about the process problem collected</li> </ol>	<ol style="list-style-type: none"> <li>1a. Ensure understanding on how the system is designed to work.</li> <li>1b. Print out PFDs and P&amp;IDs</li> <li>1c. Identify indication points that can be trended in PI or taken locally</li> <li>1d. Identify points where samples may need to be taken</li> <li>1e. Review PMO and unit mass/energy balance for discrepancies</li> <li>1f. If urgent, review with SME/BIN at beginning of investigation so that, if warranted, plans can be made for support or travel.</li> </ol>
4.	Field walk to verify piping and locations of indication points on P&ID	<ol style="list-style-type: none"> <li>1. Misunderstand actual system because PI&amp;Ds and PFDs not accurate</li> </ol>	<ol style="list-style-type: none"> <li>1a. Compare field equipment with P&amp;IDs and drawings</li> <li>1b. Confirm where indications are located (i.e. span of level indications, elevation of PI for dP calculations, upstream or downstream of control valves or bypasses)</li> <li>1c. Update drawings if inaccuracies are found</li> </ol>
5.	Take field data	<ol style="list-style-type: none"> <li>1. Wrong conclusions from inaccurate indication</li> <li>2. Design or normal data does not reflect current situation</li> </ol>	<ol style="list-style-type: none"> <li>1a. Take field measurements that pertain to the issue (temperature, pressure, flow, level, distance, pipe size, IR scan)</li> <li>1b. Identify differences with PI/DCS and have any suspect indications checked by operations or I&amp;E</li> <li>2. Develop sample plan with input from SME/BIN if necessary and coordinate</li> </ol>

			with QCD for any special test requirements, execute plan
6.	Review: data collected, historic data, design	<ol style="list-style-type: none"> <li>1. Inability to understand the process problem and be able to communicate what is occurring. Data not available to share with SME</li> <li>2. Indication leads to wrong conclusion</li> <li>3. Loss of time because a similar incident has happened in the past</li> </ol>	<ol style="list-style-type: none"> <li>1a. Identify when the issue began to occur</li> <li>1b. Check control valve position vs. Flow/Pressure/Temperature</li> <li>1c. Trend current situation and compare it to times where unit operated with similar feed composition, rate, and other pertinent process parameters</li> <li>1d. Compare with design and simulations</li> <li>2. Identify differences and have any suspect indications checked by operations or I&amp;E</li> <li>3. Check PED files and GDW to see if a similar event/issue has been documented in the past.</li> </ol>
7.	Consult with CST/Process Controls on Issue	<ol style="list-style-type: none"> <li>1. Control issue not identified</li> <li>2. Calculation is incorrect due to failure of a variable</li> <li>3. Data collection rate is insufficient to determine root cause of issue</li> </ol>	<ol style="list-style-type: none"> <li>1. Ask if issue may be related to control of process</li> <li>2. Review the calculation and check if inputs are in working order or if there is an issue that involves a calculated variable</li> <li>3. Collect more data at higher resolution, if necessary</li> </ol>
8.	Consult with an appropriate SME	<ol style="list-style-type: none"> <li>1. Not involving the right people</li> <li>2. Time lost because issues have happened in other locations and root cause/fix is previously understood</li> </ol>	<ol style="list-style-type: none"> <li>1a. Share issue and information collected from review of system with previous PE and SME or BIN.</li> <li>2a. Determine if there is a short-term and/or long term fix for the situation</li> <li>2b. Find out if issue has been observed in other locations</li> <li>2c. Ask if there are any additional items that need to be reviewed to help troubleshoot issue</li> <li>2d. Look for JLA's on troubleshooting the specific issue.</li> </ol>
9.	Perform additional checks to confirm issue	<ol style="list-style-type: none"> <li>1. Issue identified is not really the problem</li> </ol>	<ol style="list-style-type: none"> <li>1. Perform any additional tasks or testing that will independently confirm issue</li> </ol>
10.	Communicate findings	<ol style="list-style-type: none"> <li>1. Failure to follow through on action items and not notifying the right people</li> <li>2. Loss of data and troubleshooting history, loss of time</li> </ol>	<ol style="list-style-type: none"> <li>1a. Communicate findings with Customer</li> <li>1b. Share process recommendations to resolve the issue and how to mitigate risk until situation can be resolved</li> <li>2. Store pertinent information within archived documents (GDW,GMKM)</li> </ol>
11.	Complex trouble-shooting	<ol style="list-style-type: none"> <li>1. Time lost due to the process problem being more appropriate for a team to address</li> <li>2. Time lost due to unorganized approach to process problem solving</li> </ol>	<ol style="list-style-type: none"> <li>1. Bring together a team to brain-storm all potential causes</li> <li>2. Identify root cause(s) through the process of elimination using a systematic approach</li> </ol>